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Medicare Will Revise Guide to New Benefits for 2006

By [ROBERT PEAR](#)

WASHINGTON, May 21 - For two years, health policy experts have been warning that Medicare beneficiaries may be confused by complexities of the new prescription drug benefit. Now it turns out that Medicare officials were also confused, not just about the drug benefit but also about other options.

The Bush administration is revising a preliminary draft of the 2006 Medicare handbook - the main tool for educating beneficiaries - after discovering that many statements in the document were inaccurate, misleading or unclear, even to people who have worked on the program for decades.

Members of Congress, insurance companies, advocates for beneficiaries and state insurance regulators all told the Bush administration that the new handbook was flawed.

For example, in describing the drug benefit, the handbook says, "After you meet the deductible, you pay part of the cost of covered prescription drugs, and the plan pays part."

The handbook does not mention that beneficiaries face a gap in coverage. After the beneficiary pays a \$250 deductible, Medicare pays three-fourths of the next \$2,000 in drug costs. But then the beneficiary is normally responsible for all of the next \$2,850, and Medicare pays nothing. Beyond that, Medicare pays about 95 percent of drug costs.

Moreover, the handbook lumped together the traditional government-run Medicare program, which covers 36 million people, and tiny private fee-for-service health plans, in which fewer than 100,000 beneficiaries have enrolled. Both, it says, are "fee-for-service plans, available nationwide."

In fact, the two are fundamentally different. Private fee-for-service plans are available in selected counties from private insurance companies under contract to Medicare, with premiums and co-payments set by the insurers. By contrast, traditional Medicare is offered by the government throughout the country, with uniform premiums and co-payments set by law. Beneficiaries may have to pay more in some private fee-for-service plans than in traditional Medicare.

Vicki Gottlich, a lawyer at the Center for Medicare Advocacy, a nonprofit group that counsels beneficiaries, said it was "inaccurate and misleading" to emphasize the similarities between traditional Medicare and the private fee-for-service plans.

Insurers agree. In written comments, the Blue Cross and Blue Shield Association told the government: "There is no need to have pages and pages on the private fee-for-service option. Most people will think you are talking about traditional Medicare when you use that term."

Gary R. Karr, a spokesman at the Centers for Medicare and Medicaid Services, said the agency was revising the 106-page handbook to address such concerns. The handbook, he said, will include "a more detailed description" of the new drug benefit, including the gap in coverage, and will clarify the differences between traditional Medicare and private plans. The final version will be mailed to beneficiaries this fall.

"It's a real challenge to describe things accurately and completely while not giving so much detail that you overload and confuse the beneficiaries," Mr. Karr said. "It's a balancing act. The handbook is taken very seriously by beneficiaries. We've got to make sure we get it right."

Dr. Mark B. McClellan, administrator of the Centers for Medicare and Medicaid Services, said the first draft of the handbook was prepared by career employees of the Medicare agency and would be revised to reflect the comments from outside experts. "There will be changes," Dr. McClellan said. "We can communicate some things more effectively, more simply and more clearly."

When asked whether he had read the handbook, Dr. McClellan said: "I am not sure that I've read a complete draft of the handbook from cover to cover, but I am familiar with the different pieces. I will pay more attention in coming weeks and will thoroughly review the handbook before it becomes final."

A major goal of the 2003 Medicare law was to create a competitive insurance market so beneficiaries would have more options. But as the options proliferate, it becomes more difficult to explain them, especially because the terminology has changed three times in eight years.

In 1997, Congress established the Medicare+Choice program to foster the growth of health maintenance organizations and other private plans. In 2003, Congress overhauled the program and renamed it Medicare Advantage. That name, widely used in this year's handbook and in marketing materials, disappears from the draft of the 2006 handbook. H.M.O.'s and preferred provider organizations are called simply "Medicare health plans."

Traditional Medicare is also called a plan, the "original Medicare plan."

AARP, the lobby for older Americans, strongly supported the 2003 law, but now points to research suggesting that "too many options can produce paralysis." For example, it says, as the number of mutual funds in a 401(k) plan increases, the likelihood of employees' choosing any fund goes down.

In a poll on health issues by the Kaiser Family Foundation in April, two-thirds of those 65 and older said they did not understand the new drug benefit. Nine percent said they would sign up for drug coverage, 37 percent did not intend to enroll and 54 percent said they did not know or had not heard enough to decide.

John C. Rother, policy director of AARP, said his group had met several times with Medicare officials to express concerns about "the accuracy, understandability and balance" of information in the handbook.

The handbook repeatedly suggests that private plans offer a better value than the traditional Medicare program. Those plans - H.M.O.'s and P.P.O.'s - "give you more health care coverage choices and better health care benefits," it says.

In a separate notice to beneficiaries, the administration says the new Medicare drug benefit "will cover all the types of prescription drugs you may need," without noting that beneficiaries may have to appeal to get coverage for specific drugs they are using.

The new drug benefit becomes available Jan. 1. Medicare beneficiaries can sign up for it from Nov. 15 of this year to May 15, 2006. People who delay enrolling face higher premiums, with a 1 percent surcharge for each month of delay, but the handbook understates the penalty. It gives the example of a beneficiary named Hannah who has to pay 19 percent more - \$35.70 a month, rather than \$30 - because she signed up 19 months late.

Hannah "will have to pay this higher amount as long as she has this plan," the handbook says. In fact, she is likely to pay more than that amount. Her late enrollment penalty is 19 percent of her basic premium. If, as expected, the premium increases in later years, the penalty will grow with it, unless Congress changes the law.

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